

NEW ENGLAND SURGICAL SOCIETY

Virtual 27th Annual Surgical Residents and Fellow Research Presentation Day Wednesday, May 5, 2021

Research Day Abstract Submission Deadline: Monday, March 29, 2021 (11:59 pm EDT)

SUBMISSION GUIDELINES

Abstracts are now being accepted for presentation consideration at the Virtual 27th Annual Surgical Residents and Fellow Research Day. Abstract submissions are welcome from all surgical disciplines from any surgical training program, including fellowship, in the New England region, as well as from Albany Medical Center. The abstract submission deadline is **Monday, March 29, 2021 (11:59 pm EDT)**.

PREVIOUSLY PRESENTED WORK

Work that has been previously submitted and/or presented is eligible for submission at the Virtual 27th Annual Surgical Residents and Fellow Research Day. Likewise, work that is submitted and/or presented at the Virtual 27th Annual Research Presentation Day is eligible for submission to the NESS 102nd Annual Meeting (and potentially other CME accredited meetings should they accept work previously presented at non-CME accredited forums).

Authors are also encouraged to submit to the NESS Annual Meeting and will have the opportunity to present their work at both meetings. For all submissions—whether to Research Day, the Annual Meeting, or both—authors will be prompted to disclose if their work has been previously presented and/or published. Please be sure to provide this information specifying the name of the conference/publication and where it was presented and/or published.

RESEARCH DAY WINNERS

Research Presentation Day award recipients will be selected in the categories of Clinical Research and Basic Science. Award recipients will be offered a poster presentation at the NESS 102nd Annual Meeting and given the option of having their abstracts be considered for an oral presentation at that Annual Meeting. These award recipients must indicate their willingness and eligibility to have their work considered for an NESS Annual Meeting oral presentation immediately after announcement of award at the conclusion of Research Day. Please note that podium presentations at the Annual Meeting will only be allowed for original works, presented nowhere else (excluding the Research Day), per the Annual Meeting Author Instructions.

ABSTRACT CATEGORY SELECTION

This year, a category must be selected for each abstract submitted, from the following list of topic areas:

- Basic Science
- Clinical Burns/Trauma/Acute Care
- Clinical GI
- Clinical Cancer
- Clinical Pediatric Surgery
- Clinical Transplantation
- Clinical Endocrine Surgery
- Clinical Plastic Surgery
- Clinical Cardiothoracic/Vascular

- Clinical Surgical Specialties (i.e. Urology, Neurosurgery, Other)
- Quality of Life and/or Patient-Reported Outcomes
- Outcomes Studies of Patient Management
- Education and Residency Training Issues
- Social and Ethical Issues in Surgery
- Other

STRUCTURE OF ABSTRACTS FOR CONSIDERATION

Abstracts submitted for consideration for presentation at the Virtual 27th Annual Research Day **MUST** be in a Structured Abstract format and be no more than 3,000 characters (including spaces). *ABSTRACTS NOT SUBMITTED IN THIS FORMAT WILL NOT BE CONSIDERED.*

Authors reporting original data should prepare an abstract under the following headings:

1. Objective
2. Design
3. Setting
4. Patients (or Other Participants)
5. Interventions (if any)
6. Main Outcome Measure (s)
7. Results
8. Conclusions

The content following each heading should be as follows:

1. OBJECTIVE

The abstract should begin with a clear statement of the precise objective or questions addressed in the report. If more than one objective is addressed, the main objective should be indicated and only key secondary objectives stated. If a prior hypothesis was tested, it should be stated.

2. DESIGN

The basic design of the study should be described. The duration of follow-up, if any, should be stated. As many of the following terms that apply should be used.

- A. Intervention studies: randomized control trial; non-randomized control trial; double-blind; placebo control; crossover trial; before-after trial.
- B. For studies of screening and diagnostic tests: criterion standard (that is, a widely accepted standard with which a new or alternative test is being compared; this term is preferred to "gold standard") blinded or masked comparison.
- C. For studies of prognosis: inception cohort (subjects assembled at a similar and early time in the course of the disorder and followed thereafter); cohort (subjects followed forward in time, but not necessarily from a common starting point); validation cohort or validation sample if the study involves the modeling of clinical predictions.
- D. For studies of causation: randomized control trial; cohort; case-control; survey (preferred to "cross-sectional study").
- E. For descriptions of the clinical feature of medical disorders: survey; case series.
- F. For studies that include a formal economic evaluation: cost-effectiveness analysis; cost-utility analysis; cost-benefit analysis. For new analyses of existing data sets, the data set should be named and the basic study design disclosed.

3. SETTING

To assist readers to determine the applicability of the report to their own clinical circumstances, the study setting (s) should be described. Of particular importance is whether the setting is the general community, a primary care or referral center, private or institutional practice, ambulatory or hospitalized care.

4. PATIENTS OR OTHER PARTICIPANTS

The clinical disorders, important eligibility criteria and key sociodemographic features of patients should be stated. The numbers of participants and how they were selected should be provided (see below), including the number of otherwise eligible subjects who were approached but refused. If matching is used for comparison groups, characteristics that are matched should be specified. In follow-up studies, the proportion of participants who completed the study must be indicated. In intervention studies, the number of patients withdrawn for adverse effects should be given.

For selection procedures, these terms should be used, if appropriate: Random sample (where "random" refers to a formal, randomized selection in which all eligible subjects have a fixed and usually equal chance of selection); population-based sample; referred sample; consecutive sample; volunteer sample; convenience sample. These terms assist the reader to determine an important element of the generalizability of the study. They also supplement (rather than duplicate) the terms used by professional indexers when articles are entered into computerized databases.

5. INTERVENTION(S)

The essential features of any interventions should be described, including their method and duration of administration. The intervention should be named by its most common clinical name (for example, the generic term "chlorthalidone"). Common synonyms should be given as well to facilitate electronic text-word searching. This would include the brand name of a drug if a specific product was studied.

6. MAIN OUTCOME MEASURE(S)

The primary study outcome measurement(s) should be indicated as planned before data collection began. If the paper does not emphasize the main planned outcomes of a study, this fact should be stated and the reason indicated. If the hypothesis being reported was formulated during or after data collection, this information should be clearly stated.

7. RESULTS

The main results of the study should be given. Measurements that require explanation for the expected audience of the manuscript should be defined. Important measurements not included in the presentation of results should be declared. As relevant, it should be indicated whether observers were blinded to patient groupings, particularly for subjective measurements. Due to the current limitations of retrieval from electronic databases, results must be given in narrative or point form rather than tabular form if the abstract is to appear in computerized literature services such as MEDLINE. If possible, the results should be accompanied by confidence intervals (for example, 95%) and the exact level of statistical significance. For comparative studies, confidence intervals should relate to the differences between groups. For nonsignificant differences for the major study outcome measure(s), the clinically important difference sought should be stated and the confidence interval for the difference between the groups should be given. When risk changes or effect sizes are given, absolute values should be indicated so that the reader can determine the absolute as well as relative impact of the finding. Approaches such as "number needed to treat" to achieve a unit of benefit are encouraged when appropriate; reporting of relative difference alone is usually inappropriate. If appropriate, studies of screening and diagnostic tests should use the terms "sensitivity", "specificity", and "likelihood ratio". If predictive values or accuracy is given, prevalence or pretest likelihood should be given as well. No data should be reported in the abstract that does not appear in the rest of the manuscript

8. CONCLUSIONS

Only those conclusions of the study that are directly supported by the evidence reported should be given, along with their clinical application (avoiding speculation and overgeneralization), and indicating whether additional study is required before the information should be used in usual clinical settings. Equal emphasis must be given to positive and negative findings of equal scientific merit.

NOTE:

To permit quick and selective scanning, the headings outlined above should be included in the abstract. For brevity, parts of the abstract can be written in phrases rather than complete sentences.

Acceptable Example

2. Design. Double-blinded randomized trial.

Instead of

2. Design. The study was conducted as a double-blind, randomized trial